SOUTHWEST ORTHOPAEDIC CLINIC
NEW PATIENT FORM

PATIENT'S FULL NAME | PATIENT'S SOCIAL SECURITY #

ADDRESS | APT. # | PHONE NUMBER

CITY | STATE | ZIP | WORK # / CELL #

SEX ☐ F ☐ M | **MARITAL STATUS** ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED | DATE OF BIRTH

PATIENT'S EMPLOYER

EMPLOYER'S ADDRESS

SPOUSE'S/GUARDIAN'S NAME | WORK # / CELL # | DATE OF BIRTH | SOCIAL SECURITY #

EMPLOYER | ADDRESS

IN CASE OF EMERGENCY CONTACT | RELATIONSHIP | PHONE #

PRIMARY INSURANCE COVERAGE

INSURANCE COMPANY | INSURED'S DOB | ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER_____

NAME OF INSURED | COPAY AMOUNT

INSURED'S EMPLOYER

INSURANCE CLAIMS ADDDRESS | INSURANCE PHONE #

CITY | STATE | ZIP

POLICY NUMBER | GROUP NUMBER | INSURED'S SOCIAL SECURITY #

SECONDARY INSURANCE COVERAGE

INSURANCE COMPANY | INSURED'S DOB | ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER_____

NAME OF INSURED | COPAY AMOUNT

INSURED'S EMPLOYER

INSURANCE CLAIMS ADDRESS | INSURANCE PHONE #

CITY | STATE | ZIP

POLICY NUMBER | GROUP NUMBER | INSURED'S SOCIAL SECURITY #

ANY OTHER INSURANCE COVERAGE ☐ YES ☐ NO | COMPANY NAME | PHONE #

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? | PRIMARY CARE PHYSICIAN

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Southwest Orthopaedic Clinic to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to Southwest Orthopaedic Clinic. I understand that I am ultimately responsible for all services whether covered by insurance or not. I also authorize my physician, based on his/her discretion, to access my chart for utilization management review.

DATE: _____ SIGNATURE_____

SOUTHWEST ORTHOPAEDIC CLINIC
Acknowledgement of Receipt of
Notice of Privacy Practices

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand Southwest Orthopaedic Clinic reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy on the clinic website and in the physician's office. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at my appointment.

Patient's Printed Name _____ Date of Birth _____

Patient/Legal Representative Signature _____ Date _____

Relationship to Patient _____

Witness _____ Date _____

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Southwest Orthopaedic Clinic to share my protected health information with:

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

SOUTHWEST ORTHOPAEDIC CLINIC
FINANCIAL POLICY

Thank you for choosing Southwest Orthopaedic Clinic as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy.

All patients must read and sign this form prior to receiving services.

- **It is your responsibility to provide us with your most current insurance information.**
  - If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
  - We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **You are financially responsible for services not covered by your insurance company.**
  - Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.
  - **Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim – regardless of our estimation.**
  - You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.
  - We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30-days after receipt of the initial statement. You can call (915) 592-3323.
  - **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. **Past due accounts may be subject to a $5.00 monthly late fee and may be referred to a professional collection agency and/or attorney for further collection activity.** You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.
  - In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $35.00 to your original balance; in addition, we may seek all additional legal remedies provided to us under Texas law.
- **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

Full payment is due at the time of service. We accept cash, checks and credit cards. I have read and understand this Financial Policy.

Patient Name: _____

Patient Signature: _____

SOUTHWEST ORTHOPAEDIC CLINIC
Dr. Carlos Gonzalez-Sandoval
NEW PATIENT FORM

Patient Name: _____ Date: _____

Age: _____ □ Male □ Female

Primary Care Physician and Address: _____
_____
_____

Name & Address of Person who _____
Referred you to see us: _____
□ MD □ Friend □ Patient _____

Physicians who follow you regularly (Cardiologist, etc.):

_____ _____
_____ _____

Reason for Visit: _____
_____
_____
_____

Do you have pain? □ YES □ NO
If so, how long have you had this pain? (Months, Years) _____
How severe is your pain?

No Pain Severe Pain
0 1 2 3 4 5 6 7 8 9 10

Was this the result of an injury? □ YES □ NO
If yes, date of injury _____

What makes the pain better? _____

What makes the pain worse? _____

SOCIAL HISTORY:
Occupation: _____
Working: □ Full Time □ Part Time □ Student
If not working, are you: □ Retired □ On Disability □ Unemployed
Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Do you smoke tobacco? □ YES □ NO □ I QUIT
Number of packs per day: _____

Do you drink alcohol? □YES □ NO □ I QUIT
Number of drinks per week: _____

Do you use street drugs? □ YES □ NO □ I QUIT
Which drugs: _____

Are you pregnant? □ YES □ NO

PREVIOUS SURGERIES (list dates):

□ Appendectomy _____
□ Tonsillectomy _____
□ Hernia Repair _____
□ Gallbladder _____
□ Hysterectomy _____
□ _____
□ _____
□ _____

□ Knee Arthroscopy _____
_____
□ Total Knee Replacement _____
_____
□ Total Hip Replacement _____
_____
□ _____
□ _____

Have you ever had a surgical infection? □YES □NO (If yes, where? _____)
Have you ever had general anesthesia? □YES □NO
Any problems with anesthesia? □YES □NO (Problem: _____)

Current Medications: (with doses):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies to Medications:

_____ _____
_____ _____
_____ _____

Do you use any of the following:

□ Cane □ Crutches □ Walker □Wheelchair

How do you walk stairs?

□ One leg after the other (normal) □ Lead with same leg each time

Do you need a rail to walk up/down stairs? □ YES □ NO

How far can you walk before limited by pain: _____

Can you put on your own socks and shoes? □ YES □ NO

What have you tried to help the pain?

□ Ice □ Rest/ Decreased activity □ Physical Therapy

□ Pain Medication: □ Percocet □ Vicodin □ Lortab □ Oxycodone □ OxyContin

□ Anti-Inflammatory: □ Celebrex □ Aspirin □ Ibuprofen □Motrin □ Advil □ Aleve □ Naprosyn

□ Glucosamine/Chondroitin Sulfate

□ Injections

□ Hip □ Knee □ Spine □ Shoulder

When was your last injection? _____

How long did your injections last? □ ___Days □ ___Weeks □ ___Months □ ___Years

How many total injections have you had? _____

□ Orthotics □ Acupuncture □ Chiropractor □ Cane □ Brace □ Other

Have you ever had or experienced:

□Vision/Eye Problems
□ Glaucoma
□ Skin Rash
□ Migraine Headaches
□ Hearing Loss
□ Epilepsy/Seizures
□ Asthma
□ COPD
□ Emphysema
□ Dizziness
□ Shortness of Breath
□ Blood Clots in Legs
□ Peptic Ulcer Disease
□ Hiatal Hernia
□ Diverticulitis
□Gallbladder Disease
□ Tuberculosis
□ Pneumonia
□ Heart Attack

□ Heart Murmur
□ Irregular Heart Beat
□ Heart Surgery
□ High Blood Pressure
□Diabetes
□ Stroke/TIA
□ Vascular Disease
□ Weight Loss
□ Fevers/Chills
□ Swelling of Feet/Ankles
□ Blood in Stool
□ Vomiting of Blood
□ Kidney Stones
□ Kidney Failure/Dialysis
□ Blood in Urine
□ Recurrent Bladder Infections
□ Anxiety

□ Depression
□ Psychiatric Problems
□ Gout
□ Numbness
□ Cancer
  □ Breast
  □ Lung
  □ Prostate
  □ Thyroid
  □ Skin
  □ Other: _____
□ Bleeding Disorder
□ AIDS/HIV
□ Arthritis
  □ Hip
  □ Knee
  □ Lumbar Spine
  □ Cervical Spine
  □ Other: _____
□ Thyroid Disease
  □ Hypothyroidism
  □ Hyperthyroidism